

Facility Name & ID Number Briar Place Ltd.# 0031765 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsNone

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>88</u>	Skilled (SNF)	<u>88</u>	<u>32,208</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>144</u>	Intermediate (ICF)	<u>144</u>	<u>52,704</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>232</u>	TOTALS	<u>232</u>	<u>84,912</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>26,034</u>	<u>1,478</u>	<u>3,566</u>	<u>31,078</u>	8
9	SNF/PED					9
10	ICF	<u>42,599</u>	<u>2,418</u>	<u>2,983</u>	<u>48,000</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>68,633</u>	<u>3,896</u>	<u>6,549</u>	<u>79,078</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.13%

D. How many bed-hold days during this year were paid by Public Aid?

292 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/1/86

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/1/86 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 42 and days of care provided 1,744Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	327,741	37,768	20,930	386,439		386,439	(4,666)	381,773			1
2	Food Purchase		302,541		302,541		302,541	1,315	303,856			2
3	Housekeeping	163,556	45,401		208,957		208,957	(4,836)	204,121			3
4	Laundry	138,362	30,669	791	169,822		169,822		169,822			4
5	Heat and Other Utilities			196,642	196,642		196,642	1,977	198,619			5
6	Maintenance	238,867		157,067	395,934		395,934	9,000	404,934			6
7	Other (specify):*							2,124	2,124			7
8	TOTAL General Services	868,526	416,379	375,430	1,660,335		1,660,335	4,914	1,665,249			8
	B. Health Care and Programs											
9	Medical Director			18,411	18,411		18,411		18,411			9
10	Nursing and Medical Records	2,086,576	178,295	89,924	2,354,795		2,354,795	(97,737)	2,257,058			10
10a	Therapy	89,138		463	89,601		89,601		89,601			10a
11	Activities	114,605	7,254	2,136	123,995		123,995		123,995			11
12	Social Services	343,904	1,609	8,289	353,802		353,802	14,217	368,019			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							7,198	7,198			15
16	TOTAL Health Care and Programs	2,634,223	187,158	119,223	2,940,604		2,940,604	(76,322)	2,864,282			16
	C. General Administration											
17	Administrative	83,342		1,360	84,702		84,702	18,063	102,765			17
18	Directors Fees											18
19	Professional Services			372,282	372,282		372,282	(307,273)	65,009			19
20	Dues, Fees, Subscriptions & Promotions			74,723	74,723		74,723	(27,310)	47,413			20
21	Clerical & General Office Expenses	66,273	24,529	145,806	236,608		236,608	100,110	336,718			21
22	Employee Benefits & Payroll Taxes			600,672	600,672		600,672	(7,555)	593,117			22
23	Inservice Training & Education			712	712		712		712			23
24	Travel and Seminar			5,687	5,687		5,687	5,770	11,457			24
25	Other Admin. Staff Transportation			30,649	30,649		30,649	(15,000)	15,649			25
26	Insurance-Prop.Liab.Malpractice			219,497	219,497		219,497	1,112	220,609			26
27	Other (specify):*							32,453	32,453			27
28	TOTAL General Administration	149,615	24,529	1,451,388	1,625,532		1,625,532	(199,630)	1,425,902			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,652,364	628,066	1,946,041	6,226,471		6,226,471	(271,037)	5,955,434			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number Briar Place Ltd.

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Report Period Beginning:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			114,316	114,316		114,316	227,288	341,604			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			495	495		495	741,053	741,548			32
33	Real Estate Taxes			286,922	286,922		286,922	2,442	289,364			33
34	Rent-Facility & Grounds			942,530	942,530		942,530	(936,139)	6,391			34
35	Rent-Equipment & Vehicles			11,920	11,920		11,920	2,375	14,295			35
36	Other (specify):*			3,636	3,636		3,636		3,636			36
37	TOTAL Ownership			1,359,819	1,359,819		1,359,819	37,019	1,396,838			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		113,529	132,997	246,526		246,526	(8,028)	238,498			39
40	Barber and Beauty Shops			155	155		155	(155)	(0)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,368	127,368		127,368		127,368			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		113,529	260,520	374,049		374,049	(8,183)	365,866			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,652,364	741,595	3,566,380	7,960,339		7,960,339	(242,201)	7,718,138			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Briar Place Ltd.

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(251)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(21,809)	30		9
10	Interest and Other Investment Income	(155,621)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(148)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(510)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	21		24
25	Fund Raising, Advertising and Promotional	(6,313)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14,358)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(177)	20		28
29	Other-Attach Schedule	(137,078)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (396,265)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	154,064		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 154,064		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (242,201)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Briar Place Ltd.

ID# 0031765

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2	Other Income	(19,438)	21
3	Patient Clothing	(320)	10
4	Barber & Beauty	(155)	40
5	Collection Expense	(440)	21
6	Auxiliary - Pharmacy Veterans	(113,217)	10
7	Auxiliary - Oxygen Veterans	(101)	10
8	Auxiliary - Radiology Veterans	(320)	10
9	Discounts Earned	(75)	21
10	COPE	(2,820)	30
11	Non-Allowable Legal	(957)	19
12	Additional Seminar Expense	475	34
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
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94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(127,070)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(3)	518		(3,748)	(1,433)				(4,666)	1
2	Food Purchase	(399)							1,714				1,315	2
3	Housekeeping				(4,836)								(4,836)	3
4	Laundry													4
5	Heat and Other Utilities					1,977							1,977	5
6	Maintenance				(168)	2,111		7,041	16				9,000	6
7	Other (specify):*						180	1,720	224				2,124	7
8	TOTAL General Services	(399)			(5,007)	4,606	180	5,013	521				4,914	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(113,958)			(8,385)			24,606					(97,737)	10
10a	Therapy													10a
11	Activities													11
12	Social Services							14,217					14,217	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						1,518	5,680					7,198	15
16	TOTAL Health Care and Programs	(113,958)			(8,385)		1,518	44,503					(76,322)	16
	C. General Administration													
17	Administrative							17,954	109				18,063	17
18	Directors Fees													18
19	Professional Services	(957)				(306,327)			11				(307,273)	19
20	Fees, Subscriptions & Promotions	(9,829)				(17,487)			6				(27,310)	20
21	Clerical & General Office Expenses	(94,012)				19,280		174,645	197				100,110	21
22	Employee Benefits & Payroll Taxes			(531)	(661)		(6,363)						(7,555)	22
23	Inservice Training & Education													23
24	Travel and Seminar	475				5,246			49				5,770	24
25	Other Admin. Staff Transportation					(15,000)							(15,000)	25
26	Insurance-Prop.Liab.Malpractice					1,070			42				1,112	26
27	Other (specify):*						4,508	27,945					32,453	27
28	TOTAL General Administration	(104,323)		(531)	(661)	(313,218)	(1,855)	220,544	414				(199,630)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(218,680)		(531)	(14,053)	(308,612)	(157)	270,060	935				(271,037)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning:

01/01/04

Ending:

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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(21,809)	227,903			19,599				1,595			227,288	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(155,621)	896,490						6	178			741,053	32
33	Real Estate Taxes					2,442							2,442	33
34	Rent-Facility & Grounds		(942,530)			6,163			228				(936,139)	34
35	Rent-Equipment & Vehicles					2,370			5				2,375	35
36	Other (specify):*													36
37	TOTAL Ownership	(177,430)	181,863			30,574			239	1,773			37,019	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(1,579)				(3,149)	(3,300)			(8,028)	39
40	Barber and Beauty Shops	(155)											(155)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(155)			(1,579)				(3,149)	(3,300)			(8,183)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(396,265)	181,863	(531)	(15,631)	(278,038)	(157)	270,060	(1,975)	(1,527)			(242,201)	45

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning:

01/01/04

Ending:

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				GWH Limited Partnership		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent	\$ 942,530	GWH Limited Partnership	100.00%	\$	\$ (942,530)
2	V	30 Depreciation Expense		GWH Limited Partnership	100.00%	227,903	227,903
3	V	32 Interest		GWH Limited Partnership	100.00%	896,490	896,490
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 942,530			\$ 1,124,393	\$ * 181,863

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning: 01/01/04

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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 97,721	\$ 97,721	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	98,252	CCS EMPLOYEE BENEFIT GROUP	100.00%		(98,252)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 98,252			\$ 97,721	\$ * (531)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning: 01/01/04

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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	01 DIETARY	\$ 23	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 20	\$ (3)	15
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03 HOUSEKEEPING	32,596	XCEL MEDICAL SUPPLY, LLC	100.00%	27,760	(4,836)	17
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06 REPAIRS & MAINTENANCE	1,131	XCEL MEDICAL SUPPLY, LLC	100.00%	964	(168)	19
20	V	10 NURSING	56,516	XCEL MEDICAL SUPPLY, LLC	100.00%	48,131	(8,385)	20
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22 EMPLOYEE BENEFITS	4,454	XCEL MEDICAL SUPPLY, LLC	100.00%	3,793	(661)	24
25	V	39 ANCILLARY	10,640	XCEL MEDICAL SUPPLY, LLC	100.00%	9,062	(1,579)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 105,360			\$ 89,729	\$ * (15,631)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 518	\$ 518	15
16	V	05 Utilities		Care Centers, Inc.	100.00%	1,977	1,977	16
17	V	06 Maintenance		Care Centers, Inc.	100.00%	2,111	2,111	17
18	V	10 Nursing		Care Centers, Inc.	100.00%			18
19	V	11 Activities		Care Centers, Inc.	100.00%			19
20	V	19 Professional Fees	316,970	Care Centers, Inc.	100.00%	10,643	(306,327)	20
21	V	20 Dues and Subscriptions	21,170	Care Centers, Inc.	100.00%	3,683	(17,487)	21
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	19,280	19,280	22
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	5,246	5,246	23
24	V	26 Insurance		Care Centers, Inc.	100.00%	1,070	1,070	24
25	V	30 Depreciation		Care Centers, Inc.	100.00%	19,599	19,599	25
26	V	32 Interest		Care Centers, Inc.	100.00%			26
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	2,442	2,442	27
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	6,163	6,163	28
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	2,370	2,370	29
30	V	25 Bus Reimbursement	15,000	Care Centers, Inc.	100.00%		(15,000)	30
31	V	02 Food		Care Centers, Inc.	100.00%			31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 353,140			\$ 75,102	\$ * (278,038)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance Salary	\$ 1,231	Care Centers, Inc.	100.00%	\$ 1,231	\$	15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	180	180	16
17	V	10 Nursing Salary	5,451	Care Centers, Inc.	100.00%	5,451		17
18	V	10a Rehab Salary	463	Care Centers, Inc.	100.00%	463		18
19	V	11 Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12 Social Service Salary	4,464	Care Centers, Inc.	100.00%	4,464		20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,518	1,518	21
22	V	17 Administration Salary	1,360	Care Centers, Inc.	100.00%	1,360		22
23	V	21 Office Salary	29,454	Care Centers, Inc.	100.00%	29,454		23
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	4,508	4,508	24
25	V	22 Employee Benefits	6,363	Care Centers, Inc.	100.00%		(6,363)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 48,786			\$ 48,629	\$ * (157)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary Salary	\$ 8,468	Care Centers, Inc.	100.00%	\$ 4,720	\$ (3,748)	15
16	V	03 Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	7,041	7,041	17
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,720	1,720	18
19	V	10 Nursing Salary		Care Centers, Inc.	100.00%	24,606	24,606	19
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12 Social Services Salary		Care Centers, Inc.	100.00%	14,217	14,217	21
22	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	5,680	5,680	22
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	17,954	17,954	23
24	V	21 Office Salary		Care Centers, Inc.	100.00%	174,645	174,645	24
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	27,945	27,945	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 8,468			\$ 278,528	\$ * 270,060	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$ 3,385	Care Centers, Inc. - Health Systems Division	100.00%	\$ 424	\$ (2,961)
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	1,714	1,714
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	16	16
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	109	109
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	11	11
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	6	6
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	197	197
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	49	49
23	V	26 Insurance		Care Centers, Inc. - Health Systems Division	100.00%	42	42
24	V	32 Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	6	6
25	V	34 Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	228	228
26	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	5	5
27	V	39 Ancillary Enteral Supplies	6,377	Care Centers, Inc. - Health Systems Division	100.00%	3,228	(3,149)
28	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,528	1,528
29	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	224	224
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,762			\$ 7,787	\$ * (1,975)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	30 Depreciation	\$	Vent Lease, LLC.	100.00%	\$ 1,595	\$ 1,595	15
16	V	32 Interest		Vent Lease, LLC.	100.00%	178	178	16
17	V	39 Vent Reimbursement	3,300	Vent Lease, LLC.	100.00%		(3,300)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 3,300			\$ 1,773	\$ * (1,527)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	31.43%	See Attached	1.66	3.60%		\$		1
2	Adam Vales	Relative	Clerical	0%	See Attached	0.64	1.60%	CCS - VEBA	659	22-7	2
3	Mark Steinberg	Owner	Administrative	2.04%	See Attached	3.00	5.45%	CCI Salary	3,221	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,880		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS Employee Benefit Group, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 97,721	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 97,721	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Xcel Medical Supply, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation		\$	\$		\$ 20	1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation					27,760	3
4	04	LAUNDRY	Direct Allocation						4
5	06	REPAIRS & MAINTENANCE	Direct Allocation					964	5
6	10	NURSING	Direct Allocation					48,131	6
7	10A	THERAPY	Direct Allocation						7
8	12	SOCIAL SERVICE	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation					3,793	10
11	39	ANCILLARY	Direct Allocation					9,062	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 89,729	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Patient Days	1,484,397	42	\$ 9,730	\$	79,089	\$ 518	1
2	05 Utilities	Patient Days	1,484,397	42	37,103		79,089	1,977	2
3	06 Maintenance	Patient Days	1,484,397	42	39,622		79,089	2,111	3
4	10 Nursing	Patient Days	1,484,397	42			79,089		4
5	11 Activities	Patient Days	1,484,397	42			79,089		5
6	19 Professional Fees	Patient Days	1,484,397	42	199,755		79,089	10,643	6
7	20 Dues and Subscriptions	Patient Days	1,484,397	42	69,116		79,089	3,683	7
8	21 Office & Clerical	Patient Days	1,484,397	42	361,868		79,089	19,280	8
9	24 Travel and Seminar	Patient Days	1,484,397	42	98,454		79,089	5,246	9
10	26 Insurance	Patient Days	1,484,397	42	20,081		79,089	1,070	10
11	30 Depreciation	Patient Days	1,484,397	42	367,842		79,089	19,599	11
12	32 Interest	Patient Days	1,484,397	42			79,089		12
13	33 Real Estate Taxes	Patient Days	1,484,397	42	45,838		79,089	2,442	13
14	34 Rent - Building	Patient Days	1,484,397	42	115,677		79,089	6,163	14
15	35 Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		79,089	2,370	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,409,572	\$		\$ 75,102	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06 Maintenance Salary	Direct Cost			264,919	264,919		1,231	1
2	07 Emp. Ben. - Gen. Serv.	Direct Cost			38,757			180	2
3	10 Nursing Salary	Direct Cost			209,584	209,584		5,451	3
4	10a Rehab Salary	Direct Cost			66,982	66,982		463	4
5	11 Activity Salary	Direct Cost							5
6	12 Social Service Salary	Direct Cost			66,710	66,710		4,464	6
7	15 Emp. Ben. - Healthcare	Direct Cost			50,220			1,518	7
8	17 Administration Salary	Direct Cost			38,431	38,431		1,360	8
9	21 Office Salary	Direct Cost			525,935	525,935		29,454	9
10	27 Emp. Ben. - Gen. Admin.	Direct Cost			82,566			4,508	10
11	22 Employee Benefits								11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,344,103	\$ 1,172,560		\$ 48,629	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd.# 0031765

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	79,089	4,720	1
2	03 Housekeeping Salary	Patient Days	1,484,397	42			79,089		2
3	06 Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	79,089	7,041	3
4	07 Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		79,089	1,720	4
5	10 Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	79,089	24,606	5
6	10a Rehab Salary	Patient Days	1,484,397	42			79,089		6
7	12 Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	79,089	14,217	7
8	15 Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		79,089	5,680	8
9	17 Administration Salary	Patient Days	1,484,397	42	336,976	336,976	79,089	17,954	9
10	21 Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	79,089	174,645	10
11	27 Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		79,089	27,945	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,227,610	\$ 4,564,232		\$ 278,528	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Billable Income	2,144,835		93,149		9,762	424	1
2	02 Food	Billable Income	2,144,835		987,169		9,762	1,714	2
3	06 Maintenance	Billable Income	2,144,835		3,597		9,762	16	3
4	17 Administration	Billable Income	2,144,835		24,000		9,762	109	4
5	19 Professional Fees	Billable Income	2,144,835		2,500		9,762	11	5
6	20 Dues & Subscriptions	Billable Income	2,144,835		1,342		9,762	6	6
7	21 Office & Clerical	Billable Income	2,144,835		43,384		9,762	197	7
8	24 Travel & Seminar	Billable Income	2,144,835		10,755		9,762	49	8
9	26 Insurance	Billable Income	2,144,835		9,262		9,762	42	9
10	32 Interest Expense	Billable Income	2,144,835		1,371		9,762	6	10
11	34 Rent - Building	Billable Income	2,144,835		50,000		9,762	228	11
12	35 Rent - Equipment & Auto	Billable Income	2,144,835		1,080		9,762	5	12
13	39 Ancillary Enteral Supplies	Billable Income	2,144,835		98,519		9,762	3,228	13
14	01 Dietary - Salary	Billable Income	2,144,835		335,801	335,801	9,762	1,528	14
15	07 Emp. Ben. - Gen. Serv.	Billable Income	2,144,835		49,127		9,762	224	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,711,055	\$ 335,801		\$ 7,787	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30 Depreciation	Direct Billing	620,670	29	\$ 300,000	\$	3,300	\$ 1,595	1
2	32 Interest	Direct Billing	620,670	29	33,493		3,300	178	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 333,493	\$		\$ 1,773	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Premier Bank		X	Auto Loan	\$355.61	4/4/03	\$ 11,583	\$ 5,433	4/06	6.5000	\$ 495	1	
2	White Oak Nursing Center		X	Mortgage	\$78,544.00	3/1/97	7,441,383	6,812,401	11/01/21	12.0000	893,374	2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	5/3 Bank		X	Working Capital				6,031			3,116	6	
7	CCI Health System Alloc.		X								6	7	
8	See Supplemental Schedule										178	8	
9	TOTAL Facility Related				\$78,899.61		\$ 7,452,966	\$ 6,823,865			\$ 897,169	9	
	B. Non-Facility Related*												
10												10	
11												11	
12	Interest Income		X								(155,621)	12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ (155,621)	14	
15	TOTALS (line 9+line14)						\$ 7,452,966	\$ 6,823,865			\$ 741,548	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Allocated From Ventlease		X				\$	\$			\$	178	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital											178	14
	B. Non-Facility Related*												
15							\$	\$			\$		15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

- * Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- ** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENTFACILITY NAME Briar Place Ltd. COUNTY CookFACILITY IDPH LICENSE NUMBER 0031765CONTACT PERSON REGARDING THIS REPORT Steve LavendaTELEPHONE (847)236-1111 FAX #: (847)236-1155**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>18-20-102-035</u>	<u>Long Term Care Facility</u>	\$ <u>279,621.75</u>	\$ <u>279,621.75</u>
2. <u>Care Centers Allocation</u>	<u>Home Office Allocation</u>	\$ <u>106,873.39</u>	\$ <u>2,442.26</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>386,495.14</u></u>	\$ <u><u>282,064.01</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet: 65,200
 B. General Construction Type:
 Exterior Brick
 Frame
 Number of Stories 5

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1997	\$ 402,069	1
2	2201 West Main Allocation			18,739	2
3	TOTALS			\$ 420,808	3

B. Building Depreciation-Including Fixed Equipment.

(See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various	1986	5,000		20	263	263	4,767	9
10	Various	1987	138,915		20	7,310	7,310	129,151	10
11	Various	1988	9,885		20	519	519	8,681	11
12	Various	1989	5,410		20	264	(264)	4,048	12
13	Various	1990	42,578		20	2,130	2,130	31,004	13
14	Various	1991	11,813		20	591	591	8,176	14
15	Various	1992	11,426		20	571	571	7,043	15
16	Various	1993	8,851		20	443	443	6,836	16
17	Various	1994	25,632		20	1,282	1,282	13,160	17
18	Various	1995	50,028		20	2,502	2,502	23,890	18
19	Various	1996	161,111		20	8,053	8,053	63,762	19
20	Various	1997	165,320		20	8,266	8,266	64,698	20
21	Various	1998	185,999		20	9,301	9,301	61,463	21
22	Various	1999	23,879		20	1,177	1,177	6,468	22
23	Various	2000	122,845		20	6,171	6,171	27,130	23
24						-		-	24
25						-		-	25
26						-		-	26
27						-		-	27
28						-		-	28
29						-		-	29
30						-		-	30
31						-		-	31
32						-		-	32
33						-		-	33
34						-		-	34
35						-		-	35
36						-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		7,041,541	164,470		183,266	18,796	1,281,494	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		72,292	2,970		2,970		6,165	68
69	Financial Statement Depreciation			114,316			(114,316)		69
70	TOTAL (lines 4 thru 69)		\$ 8,082,525	\$ 281,756		\$ 235,079	\$ (47,205)	\$ 1,747,936	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,082,525	\$ 281,756		\$ 235,079	\$ (46,677)	\$ 1,747,936	1
2	Elevator Elec	2001	7,450		20	373	373	1,491	2
3	Hvac	2001	1,792		20	90	90	352	3
4	Cable Jacks	2001	723		20	36	36	138	4
5	Cabinets	2001	753		20	38	38	142	5
6	Gas Hose	2001	543		20	27	27	101	6
7	Pump	2001	760		20	38	38	139	7
8	Pain	2001	789		20	39	39	141	8
9	Drians	2001	567		20	28	28	101	9
10	Sprinkler Heads	2001	1,130		20	57	57	203	10
11	Motor	2001	721		20	36	36	129	11
12	Paint	2001	681		20	34	34	119	12
13	Paint	2001	1,199		20	60	60	205	13
14	Paint	2001	1,006		20	50	50	172	14
15	Alarm Repair	2001	537		20	27	27	92	15
16	Fire Alarm	2001	1,425		20	71	71	244	16
17	Fire Alarm	2001	1,425		20	71	71	244	17
18	Gas Pipe	2001	725		20	36	36	121	18
19	Fire Alarm	2001	1,425		20	71	71	238	19
20	Plumbing	2001	660		20	33	33	107	20
21	Tiling	2001	4,172		20	209	209	678	21
22	Plumbing	2001	509		20	25	25	82	22
23	Plumbing	2001	643		20	32	32	104	23
24	Masonry	2001	3,000		20	150	150	475	24
25	Hand Rail	2001	1,624		20	81	81	258	25
26	Ejector Pump	2001	3,275		20	164	164	518	26
27	Code Alert	2001	(1,676)		20	(84)	(84)	(265)	27
28	Antennas	2001	1,340		20	67	67	262	28
29	Door Closers	2001	565		20	28	28	113	29
30	Roofing	2001	500		20	25	25	98	30
31	Faucet	2001	573		20	29	29	113	31
32	Control Unit	2001	503		20	25	25	100	32
33	Control Unit	2001	1,353		20	68	68	265	33
34	TOTAL (lines 1 thru 33)		\$ 8,123,217	\$ 281,756		\$ 237,113	\$ (44,643)	\$ 1,755,216	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,123,217	\$ 281,756		\$ 237,113	\$ (44,643)	\$ 1,755,216	1
2	Device For Elevator	2001	2,000		20	100	100	392	2
3	Alarm Device	2001	2,475		20	124	124	474	3
4	Keypad	2001	685		20	34	34	131	4
5	Tile	2001	1,681		20	84	84	294	5
6	Valves	2001	1,605		20	80	80	274	6
7	Paint	2001	1,282		20	64	64	213	7
8	Id Console	2001	676		20	34	34	112	8
9	Transformer	2002	644		20	92	92	276	9
10	Cooler Door	2002	1,850		20	123	123	288	10
11	P A Amplifier	2002	690		20	99	99	222	11
12	Walk In Freezer Repair	2002	607		20	87	87	188	12
13	Sprinkler System	2002	2,000		20	200	200	600	13
14	Paint	2002	678		20			678	14
15	Tuckpointing	2002	5,100		20	510	510	1,530	15
16	Door Closers	2002	3,270		20	327	327	981	16
17	Smoke Damper	2002	3,520		20	293	293	880	17
18	Program Alarm	2002	874		20	125	125	375	18
19	Fire Safety Eval	2002	2,919		20	417	417	1,216	19
20	Roof Maintenance	2002	3,650		20	365	365	1,065	20
21	Flooring	2002	2,874		20	192	192	559	21
22	Plumbing Repair	2002	766		20	77	77	217	22
23	Plumbing Repair	2002	613		20	61	61	169	23
24	Rod Out Sewer	2002	860		20	86	86	229	24
25	Plumbing	2002	603		20	60	60	146	25
26	Paint	2002	557		20			557	26
27	Plumbing	2002	603		20	60	60	136	27
28	Windows	2002	36,000		20	3,600	3,600	8,100	28
29	Paint	2002	828		20			828	29
30	Digital Card-Phone	2003	573		20	57	57	115	30
31	Duct-Gener Rm	2003	1,480		20	74	74	148	31
32	Plumbing Work	2003	5,470		20	274	274	547	32
33	Panic Devices	2003	1,402		20	140	140	280	33
34	TOTAL (lines 1 thru 33)		\$ 8,212,052	\$ 281,756		\$ 244,952	\$ (36,804)	\$ 1,777,436	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Page 12D

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,212,052	\$ 281,756		\$ 244,952	\$ (36,804)	\$ 1,777,436	1
2	Hospital Latch	2003	1,856		20	186	186	371	2
3	Refractory Replace.	2003	3,228		20	323	323	646	3
4	Ignition Module	2003	570		20	29	29	57	4
5	Repair Frozen Coils	2003	1,660		20	83	83	166	5
6	Repair Leak Turbo Charger	2003	1,450		20	73	73	145	6
7	Rep. Walk In Freezer	2003	524		20	26	26	52	7
8	New Windows	2003	66,234		20	6,623	6,623	12,695	8
9	Paint	2003	1,015		20	101	101	194	9
10	Part For Boiler	2003	697		20	35	35	67	10
11	Plumbing Repair	2003	1,010		20	101	101	194	11
12	Coils	2003	4,900		20	327	327	599	12
13	Testing Of Coils For Leaks	2003	720		20	48	48	88	13
14	Generator	2003	1,449		20	72	72	133	14
15	Generator	2003	1,960		20	98	98	180	15
16	Paint Job	2003	931		20	93	93	163	16
17	Replaced Refractory Tiles	2003	3,228		20	161	161	282	17
18	Boiler	2003	1,290		20	64	64	113	18
19	A/C Parts	2003	586		20	29	29	46	19
20	Void	2003	(925)		20	(92)	(92)	(146)	20
21	Plumbing Equipment	2003	658		20	66	66	99	21
22	Fresh Air Dampers	2003	3,000		20	150	150	225	22
23	A/C Repair	2003	1,486		20	74	74	105	23
24	Generator	2003	1,132		20	57	57	80	24
25	Tar Coating On Parking Lot	2003	2,471		20	247	247	350	25
26	Paint	2003	685		20	69	69	91	26
27	Fence Repair	2003	550		20	55	55	73	27
28	4 New Doors	2003	3,650		20	365	365	487	28
29	Repair Of Air Handling Unit	2003	1,342		20	67	67	84	29
30	Installed Detector & Door Screen	2003	1,526		20	76	76	95	30
31	Water Heater Repair	2003	585		20	29	29	37	31
32	Generator Maintenance	2004	1,223		20	204	204	204	32
33	Labor & Equip. For Plumbing	2004	735		20	98	98	98	33
34	TOTAL (lines 1 thru 33)		\$ 8,323,478	\$ 281,756		\$ 254,889	\$ (26,867)	\$ 1,795,509	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,323,478	\$ 281,756		\$ 254,889	\$ (26,867)	\$ 1,795,509	1
2	Retailing Of Shower Stalls	2004	10,000		20	583	583	583	2
3	Installation Of Sprinkler Heads	2004	9,300		20	543	543	543	3
4	Parts For Doors	2004	1,925		20	64	64	64	4
5	Repair On Sewage Pump	2004	1,243		20	83	83	83	5
6	Dp On New 2Nd Floor Showers	2004	4,000		20	67	67	67	6
7	Generator Repair	2004	620		20	21	21	21	7
8	Sprinkler System Repair	2004	2,295		20	76	76	76	8
9	Glass Frames & Door Hinges	2004	748		20	12	12	12	9
10	Glass Frames & Door Hinges	2004	518		20	9	9	9	10
11	Fire Dampers	2004	581		20	7	7	7	11
12	Installation Of Window	2004	1,275		20	21	21	21	12
13	Painting	2004	774		20	39	39	39	13
14	Gas Valve Repair	2004	733		20	31	31	31	14
15	Painting	2004	1,065		20	44	44	44	15
16	Plaster & Paint Rooms	2004	7,000		20	146	146	146	16
17	Asphalt Patching	2004	1,200		20	25	25	25	17
18	Walk In Cooler Repair	2004	870		20	15	15	15	18
19	Air Filters	2004	758		20	6	6	6	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12F, Carried Forward		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301
2								
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28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,368,383	\$ 281,756		\$ 256,681	\$ (25,075)	\$ 1,797,301	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)										
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation
4	232		1997		\$ 7,041,541	\$ 164,470		\$ 183,266	\$ 18,796	\$ 1,281,494
5										
6										
7										
8										
9	Improvement Type**									
10										
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36										

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,041,541	\$ 164,470		\$ 183,266	\$ 18,796	\$ 1,281,494	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)										
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation
4	Allocated From 2201 West Main		2002		\$ 25,823	\$ 646	35	\$ 646		\$ 1,614
5										
6										
7										
8										
Improvement Type**										
9	Allocated From 2201 West Main		2002		21,331	1,067	20	1,067		2,666
10	Allocated From 2201 West Main		2003		25,138	1,257	20	1,257		1,885
11										
12										
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36										

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 72,292	\$ 2,970		\$ 2,970	\$	\$ 6,165	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,904,029	\$ 71,231	\$ 60,673	\$ (10,558)	10	\$ 1,690,372	71
72	Current Year Purchases	93,980	7,697	15,624	7,927	10	15,624	72
73	Fully Depreciated Assets	174,819				10	174,819	73
74								74
75	TOTALS	\$ 2,172,828	\$ 78,928	\$ 76,297	\$ (2,631)		\$ 1,880,815	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		AUTOS - SEE ATTACHED		\$ 79,707	\$	\$ 5,897	\$ 5,897	5	\$ 54,924	76
77		Prior Year CCI Allocatoin	2003	36,392	2,646	2,646		5	30,647	77
78		Current Year CCI Allocation	2004	555	83	83		5	83	78
79										79
80	TOTALS			\$ 116,654	\$ 2,729	\$ 8,626	\$ 5,897		\$ 85,654	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,078,673	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 363,413	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 341,604	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (21,809)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,763,770	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated From Care Centers, Inc.				6,163			5
6	Allocated From CCI Health Systems				228			6
7	TOTAL				\$ 6,391			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 6,653

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Lincoln	\$ 625.00	\$ 7,641	17
18					18
19					19
20					20
21	TOTAL		\$ 625.00	\$ 7,641	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$		\$	\$
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$		\$		\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 59,750	\$		\$ 59,750	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			804			804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			72,443			72,443	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				67,481		67,481	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						46,048		46,048	13
14	TOTAL			\$		\$ 132,997	\$ 113,529		\$ 246,526	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,400	\$ 2,400	1
2	Cash-Patient Deposits	62,847	62,847	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,715,676	1,715,676	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	237,777	237,777	6
7	Other Prepaid Expenses	4,863	4,863	7
8	Accounts Receivable (owners or related parties)	219,320	6,071	8
9	Other(specify): See Attached Schedule	2,574,349	2,574,349	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,817,232	\$ 4,603,983	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		402,069	13
14	Buildings, at Historical Cost		6,414,314	14
15	Leasehold Improvements, at Historical Cost	1,119,827	1,119,827	15
16	Equipment, at Historical Cost	1,028,168	2,253,168	16
17	Accumulated Depreciation (book methods)	(1,204,188)	(3,710,684)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		8,391	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(8,391)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 943,807	\$ 6,478,694	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,761,039	\$ 11,082,677	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,478,081	\$ 1,478,081	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60,688	60,688	28
29	Short-Term Notes Payable	5,433	11,464	29
30	Accrued Salaries Payable	248,303	248,303	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,392	19,392	31
32	Accrued Real Estate Taxes(Sch.IX-B)	293,600	293,600	32
33	Accrued Interest Payable		68,124	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	5,000	5,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,110,497	\$ 2,184,652	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,812,401	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,812,401	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,110,497	\$ 8,997,053	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,650,542	\$ 2,085,624	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,761,039	\$ 11,082,677	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,012,362	1
2	Restatements (describe):		2
3	See Attached	26,107	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,038,469	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	972,573	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(360,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 612,073	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,650,542	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,617,566	1
2	Discounts and Allowances for all Levels	(561,122)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,056,444	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	493,870	6
7	Oxygen	4,547	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 498,417	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	251	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	164,775	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,593	19
20	Radiology and X-Ray	1,850	20
21	Other Medical Services	18,398	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 201,867	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	155,621	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 155,621	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	20,563	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,563	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,932,912	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,660,335	31
32	Health Care	2,940,604	32
33	General Administration	1,625,532	33
	B. Capital Expense		
34	Ownership	1,359,819	34
	C. Ancillary Expense		
35	Special Cost Centers	246,681	35
36	Provider Participation Fee	127,368	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,960,339	40
41	Income before Income Taxes (line 30 minus line 40)**	972,573	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 972,573	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Finished If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Briar Place Ltd.

0031765

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,050	2,368	\$ 85,310	\$ 36.03	1
2	Assistant Director of Nursing	1,285	1,536	46,674	30.39	2
3	Registered Nurses	14,409	16,071	441,313	27.46	3
4	Licensed Practical Nurses	26,415	29,055	671,738	23.12	4
5	Nurse Aides & Orderlies	75,034	80,832	809,536	10.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,224	5,873	89,138	15.18	8
9	Activity Director	1,689	2,058	28,346	13.77	9
10	Activity Assistants	9,487	10,773	86,259	8.01	10
11	Social Service Workers	22,160	24,550	343,904	14.01	11
12	Dietician	1,819	2,033	25,854	12.72	12
13	Food Service Supervisor	1,896	2,134	38,133	17.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,481	30,269	263,754	8.71	15
16	Dishwashers					16
17	Maintenance Workers	19,134	21,154	238,867	11.29	17
18	Housekeepers	18,941	20,946	163,556	7.81	18
19	Laundry	14,731	16,047	138,362	8.62	19
20	Administrator	2,047	2,103	59,563	28.32	20
21	Assistant Administrator	625	840	23,779	28.31	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,293	5,814	66,273	11.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,944	2,193	32,005	14.59	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	251,664	276,649	\$ 3,652,364 *	\$ 13.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	287	\$ 12,462	01-03	35
36	Medical Director	Monthly	18,411	09-03	36
37	Medical Records Consultant	Monthly	931	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,430	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,136	11-03	44
45	Social Service Consultant	19	999	12-03	45
46	Other(specify) CCI - See Attached		18,846		46
47	Psychiatrist Consultant	Monthly	3,000	10-03	47
48	Psycho Social Consultant	55	2,826	12-03	48
49	TOTAL (lines 35 - 48)	405	\$ 62,041		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	168	\$ 8,298	10-03	50
51	Licensed Practical Nurses	2,045	66,914	10-03	51
52	Nurse Aides	100	2,900	10-03	52
53	TOTAL (lines 50 - 52)	2,313	\$ 78,112		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description		Amount	
Jeremy Boshes	Administrator		\$ 59,563	Workers' Compensation Insurance		\$ 74,270	IDPH License Fee		\$ 3,320	
Linda Peterson (3/15-4/4)	Assistant Admin		713	Unemployment Compensation Insurance		47,279	Advertising: Employee Recruitment		24,280	
Bonzetta Williams (1/1-3/10)	Assistant Admin		5,707	FICA Taxes		278,557	Health Care Worker Background Check (Indicate # of checks performed <u>68</u>)		1,151	
Hilda Derzsy	Assistant Admin		17,359	Employee Health Insurance		175,350	<u>Licenses & Permits</u>		9,265	
				Employee Meals			ILCLTC		8,279	
				Illinois Municipal Retirement Fund (IMRF)*			<u>Dues & Subscriptions</u>		960	
				Employee Physicals		3,966	CLIA Program Lab		150	
				Other Employee Welfare		9,867	<u>Allocated From CCI Health Systems</u>		6	
				Holiday Expense		3,828				

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

<p>Facility Name & ID Number Briar Place Ltd.</p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>Illinois Council on Long Term Care \$11,108.16</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10 Years</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>159</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.</p> <hr/> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>127,368</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># 0031765 Report Period Beginning: 01/01/04 Ending: 12/31/04 Page 23</p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>Yes</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ <u>N/A</u></p> <p>(16) Travel and Transportation</p> <p style="padding-left: 20px;">a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation.</p> <p style="padding-left: 20px;">b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u></p> <p style="padding-left: 20px;">c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% line 14</u></p> <p style="padding-left: 20px;">d. Have vehicle usage logs been maintained? <u>Yes</u></p> <p style="padding-left: 20px;">e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u></p> <p style="padding-left: 20px;">f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u></p> <p style="padding-left: 20px;">g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: <u>N/A</u> The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? <u>N/A</u> If no, please explain. <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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SEE ACCOUNTANTS' COMPILATION REPORT